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ABSTRACT

A detailed approach in how to incorporate the principles of Milton Erickson into counseling therapy is presented here. Since Ericksonian therapy emphasizes practical results, the paper opens with ways to apply Erickson's work. It emphasizes a philosophical framework where the therapist is clear in what he or she is doing and where a definitive goal is envisioned. This involves communicating clearly with the client and recognizing the unique components of each client's story. Characteristics of Erickson's work are then described, including his use of creativity and outrageous acts. Emphasis is placed on the importance of initial approaches in therapy, since all aspects of therapy will follow this first formulation. It is argued that therapists should fix what is wrong and a description of the source of therapeutic change is provided, such as experiential change, unconscious functioning, and responsible identity formation. How change occurs is also important to the process and some of the hypnotic principles that Erickson employed, such as reframing, concentrated effect, control dominant effect, and symptom alteration are discussed. The paper closes with an overview on ending therapy and claims that the therapeutic process does not really end and that a client will always remain a client. (RJM)

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THERAPEUTIC REALITIES
A Guide to Doing Brief Ericksonian Therapy

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1997

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THERAPEUTIC REALITIES
A Guide to Brief Ericksonian Therapy

DOING BRIEF ERICKSONIAN THERAPY: A PRACTICAL MODEL

The following outlines a framework for doing therapy based on concepts central to Erickson's work.

I. Applying Erickson's work

Zen Koans: A Philosophical Framework

Don't wander. To be most effective, you need to know what you're doing. Good therapy is not the result of an unconscious, rambling process that unfolds automatically. A therapist needs to formulate an individualized plan of action for each case and be clear about where treatment is going when starting to intervene. You should be aware of your own decision-making process and take responsibility for assessing feedback about the appropriateness of your strategy.

It may feel safer to avoid making choices, but a rudderless ship gets lost and rarely to its destination. It's usually better to stick your neck out, be wrong, and regroup, than to hedge and get nowhere. Especially with the tight time frame of treatment today, it's better to swim than to drown. We need to choose to commit to a course of action, take the risk of acting boldly on that choice, assess the impact of our intervention, and modify our tactics as appropriate, to cram as much power into treatment as we can. Without a carefully considered framework, there is no solid treatment.

Most of the work on Erickson focuses on the middle phases of therapy, and all the creative, ingenious, and complex interventions he made to bring about change. His work appears mysterious and intuitive. But therapists need to be more aware of how systematic and empirical his work really was. This is made clear when the initial phases of his therapeutic work are considered. These are the most important, because decisions made early on shape all that follows in therapy. Unfortunately, Erickson did not elaborate this beginning part of the process much in his writing. Nor have others. This is a shame because all that follows in his work is fully understandable only in terms of the goals he initially selected. For Erickson, therapy was always focused on a definitive goal, which gave shape to all that he did. Most of the time this goal was defined by what the patient wanted. Erickson wasted neither time nor effort in getting to the specified goal.

In practice, doing therapy this way may be unnerving, even for many therapists who may agree in principle that therapy needs to be focused on a delimited goal. In conducting sessions, many such therapists are likely to wander about, devoting considerable energy to discussing and explaining, rather than to doing. Many therapists may pay lip service to the principle of directed action, but tell themselves that they need to get to know the client first and therefore stall getting started. But right from the start, Erickson would be clear in his mind about why he was doing therapy with a given individual. He rapidly made decisions about the goal of therapy, and would immediately work toward the goal. He held

the therapeutic process accountable for change in a way that many therapists don't. He clearly visualized the endpoint he desired, and imagined the necessary steps to his objective by thinking in reverse. In reading his cases, one needs to work backwards to get a sense of where he began, and what his implicit goal was at the outset. Then what he elected to do makes much more sense. Further, this provides a better sense of the fact that the problems he addressed could have been approached in many different ways, at many different levels. The particular techniques he chose to use were not all that important. What was important was that he forced himself to make the conscious choice. If one technique did not work, Erickson was the first to try another one.

What works depends heavily upon what you as a therapist want to accomplish. It is very important to be able to articulate the outcome you desire in specific terms. If you do not, therapy becomes a cloudy endeavor, its path like that of a rudderless ship. There is a rule of therapy that at least one of the people in the room needs to know why they are there if therapy is going to get anywhere. In many cases, that person has often been the client. Therapists need to get beyond theory-based goals, which are often broad, general, and may have little to do with what the client really wants. Once you know where you want to go, much of the mystery of what to do disappears.

Ericksonians: Milton and Us

Great therapy doesn't go on inside the therapist's head. The measure of great treatment isn't how well the therapist understands

the client, but how well the client lives his life. Generating creative, clever, internally consistent, parsimonious explanations of the client's life is not the goal of treatment. Therapy should be directed at satisfying the client's need for a practical solution, rather than at satisfying the therapist's intellectual need for a story that makes sense. Rather than use clients to support our theoretical world view (complete with interesting assumptions about the impact of early family dynamics), or refine a standard treatment approach that we'll pull out time and again, as therapists, we should try to use all our energy to tailor what we do completely to each new client's individual need (what they need to learn and how they learn best). Each case should be an adventure. . . a first.

Within this framework, the therapist is not focused on developing a standard approach to therapy. This mode of therapy does not aim to become programmatic, for therapists should never let themselves become mere technicians. To the degree that they do, therapy becomes stale and a grind. When the same old techniques are applied in the same old way, to the same old problems, the process is less effective. Therapy loses its freshness and challenge. Using our approach, the therapist avoids looking at patients as diagnostic labels or at cases in terms of specialized treatment programs. Although much can be learned empirically about common presenting problems, and although the therapist may sometimes choose to employ similar techniques in similar cases, therapy should still emphasize the uniqueness of

each client's case.

The practice of therapy should resemble the use of language: there are certain rules of grammar and there is a vocabulary of words, but novelty is possible in the creation of sentences. Traditional schools of therapy have taught a limited vocabulary and offered a restricted menu of techniques to therapists, rather than portraying therapy as a language that can be developed by each therapist in their own way, to generate their own creative solutions to client's problems. In a similar vein, Talk's Body discusses improvisation in music. Good musicians, once they learn the basics, can improvise music. They can take a tune and work variations on it; they can develop a theme, and go in novel directions with the song they are playing. In therapy, traditional approaches have sought to teach therapists to follow a standard score and play the same song with little variation. A grasp of the underlying structure of therapy, like that of music or language, has been lacking. Erickson was the first to see this in an intuitive way and use it in his work. Approaching his work is like learning a new language: one needs to learn the words, the grammar, and use them to develop a new means of communicating. This becomes frustrating for therapists who seek to learn a few choice intervention techniques, the "correct" song, and the "right" words necessary to treat all clients.

Therapists have sought to simplify the treatment process by looking for the standard "causes" of problems and the standard "cures". Although there has been some movement away from this

tendency (thanks in large part to Erickson), many therapists still struggle with Erickson's work, because in some ways they have not given up this implicit standardized approach to therapy. Too many therapists focus on Erickson's specific intervention techniques, rather than on the framework of his work. There is a need to examine and discard some of these implicit assumptions about the value of a regimented, scientific, "stock" therapeutic process, and to move away from the idea of being a technician to that of being an artist learning to create and improvise in terms of the uniqueness of each patient.

Outcomes: Getting to Your Goal

You will help most people that see you. Generally, research has shown that most people are helped by therapy. Usually, if you are a mature, intelligent, empathetic person, you will be able to help most of the clients you see in therapy. Your effectiveness will only be limited by your rigidity in doing therapy, and the client's capacity and desire to change. Most outpatients are motivated and responsive to the right therapeutic messages. Although patients with severe diagnosed mental disorders such as schizophrenia will require more intensive therapy than other patients, and the gains by and large will be small in many cases, even these patients can be aided in pursuing their goals.

But it is helpful to keep in mind that most people are not in therapy today because of actual diagnosed "clinical" problems. The

majority of people that enter therapy are there for help with practical, everyday problems in living. The truly psychopathological are fairly rare. Most people have greater problems with the philosophy and practicality of everyday living than they do with formal mental illness. However, our diagnostic nomenclature often fails to reflect this reality, and in fact sometimes suggests otherwise. Beginning in 1980, with the revision of the diagnostic manual, DSM-III, the aim was to eliminate the pejorative term of "neurosis", which was viewed as being too theoretical and inclusive. Making the diagnostic categories more precise and empirical excluded a large number of individuals that formerly would have been diagnosed and labeled psychopathological. This new system often fails to embrace the majority of clients we as clinicians seek to treat; they don't fit into any of the new delimited, clinical categories. Thomas Szasz attacked what he saw as the "myth of mental illness", and said that most clients are best understood as having "problems in living" rather than a psychiatric disease. Concomitant with this, the pioneering cognitive-behavioral work of Albert Ellis and Aaron Beck urged therapists to focus more and more on the presenting problems of patients. These approaches have increasingly moved therapy away from a clinical context and toward a problem-solving one. Therapy is becoming stripped of terms such as "symptoms", "resistance", "need for insight", "cure", and even "patient". To paraphrase Wittgenstien, many of the difficulties that arise in therapy arise because of the way in which the therapist poses the questions. For

example, when homosexuality was viewed in psychoanalytic terms as being the result of a faulty resolution of the oedipal complex, it was assumed necessarily to be a pathological process requiring therapy. This view was only officially changed in 1973. Until then, rather than offer suggestions about how to cope constructively with a stressful, minority lifestyle, therapists felt obliged to change their homosexual clients' deeply rooted sexual preference. The fact that their efforts almost exclusively met with failure greatly frustrated both clients and therapists alike, but for a long time failed to stimulate a reevaluation of the assumptions underlying treatment.

The way in which therapists view clients' problems can have a negative and harmful impact on clients. When as therapists we lose our clinical baggage, our views of clients change. We may decide that their lack of success stems not from illness or inadequacy, but from a failure to have learned more efficient solutions. Clients may need to rethink their views. They may need to explore alternatives, and become more creative. But they are not assumed to require arduous personality reconstruction. It is far better to be optimistic about clients. This may be half the cure! Stripped of the clinical, what remains in therapy is the everyday, the practical. The client is like us, struggling with the same everyday challenges of being alive. We may be able to help him or her in this struggle by using what we know. For we still have expertise in problem-solving and experiential learning. We can teach and teach efficiently. Jettisoning the notion of

psychopathology does not necessarily do away with "experts". We as therapists just become cast as experts of another kind. Through our work, we gather a broader base of experiences and solutions than most people accumulate, and we use this as a basis to help others. The point is that to become such an expert, we have to be on the right track. As we view problems that clients have in these new ways, we will find that doing therapy may be simpler than we previously thought. Most people we see may need much less help than we originally believed. As the story of stone soup shows, the patient comes to therapy with all the ingredients for the solutions they need. The therapist may need only to lead the way and then stir the broth a little.

If a client does not genuinely want to change, therapy may be sought by the client for other reasons, such as airing grievances, getting the therapist angry, using therapy to stay the way they are, to excuse misbehavior, etc. These situations will be fairly easy to discern, for the patient will make little progress over a number of sessions, even though their capacity to change exists. But it is incorrect to assume that resistance is the norm, and to encumber the therapeutic process with unnecessary, time-consuming remedies for it.

But generally, therapy helps. The following guidelines from Erickson's work are offered to facilitate therapy and make it easier, faster, and more effective. What Erickson did in many ways is indicative of what is desirable in all forms of therapy, and is usually present in some form when therapy succeeds.

II. Characteristics of Erickson's work

Creativity: Making Each Moment Matter

Avoid assumptions about the dynamics of a client's problems. Therapy need not be programmatic, but should focus on creative solutions to a client's problems. Many therapists make the assumption that if they directly gave a client their opinion about the client's problems, and recommended specific steps the client should take to resolve the problems, it would not be helpful. These therapists assume the client would not do what their therapist suggested, because of some psychodynamic process of resistance. These therapists feel that the client needs to labor first to reach a point of readiness to change, through some extended programmatic therapeutic process. This notion derives from Freud's work. Freud felt it was not desirable to be straightforward with clients. In one of his essays, he talked about a "wild analysis" in which he directly told a client about his oedipal strivings, but failed to convince the client. This led him to conclude that more was needed than knowledge alone. The possibility that the idea's rejection stemmed from other causes was dismissed, quite possibly prematurely. Perhaps we should give clients more credit and not automatically assume that sound directive advice would always go unused. Many clients profit a great deal from simple and simply offered solutions.

Many therapists have concluded that offering straightforward suggestions would fail on the basis of their experiences with an

unrepresentative subset of clients. There is a small group of clients whose agenda is not therapeutic change. Some are immature and use therapy to "play games" and get the therapist's attention. With this group of clients, their problem quickly becomes evident to a therapist using a straightforward approach, because the client refuses to do anything to get better and fails to act on suggestions. But most clients that come to therapy view their problems in practical terms and really desire change. They have trouble at work, they're anxious about driving, their kids are failing in school, they fight with their wives, etc. They are seeking practical solutions that they are willing to implement.

Allen (1977) pointed out that therapist expectations often exceed client expectations in therapy. Clients aren't asking for a personality transformation, nor do they usually want change of such magnitude. If therapists pigheadedly try to create such transformation, they probably will encounter resistance. But if therapists attend to the client's preferences, and proffer what is requested, they most wisely should view their client as an eager, even impatient ally, resentful of condescension and being kept in the dark.

With this in mind, it is useful to frame the problem that a client presents as a practical matter and to work together to seek creative, inventive solutions to it. In doing so, a therapist can recall what worked with similar clients, what psychological principles are involved, etc. For example, in the case discussed in a previous chapter, Erickson had the domineering husband give

his wife a choice of 20 house plants. This satisfied the wife, and she felt involved. Simultaneously, the husband still felt in control. We were surprised at how much this resembled lessons offered in a managerial workshop we had attended, in which differing types of decision-making were discussed. In the model reviewed, subordinates were given varying degrees of involvement in the decision-making process, from little or no involvement to total involvement. Translating such organizational concepts for personal application can definitely improve relationships. Here, modifying the husband's decision making style to allow his wife greater involvement produced the expected marital gains. There is a great deal of practical knowledge about motivating and changing human behavior that can be applied to therapy, if we give up our often unwarranted assumptions about psychodynamic processes.

As therapists we need to have more faith in our clients' creativity. A great deal of the time clients come to therapy primed with solutions. We as therapists need to tap into that creative potential. This is much easier to do when we give up our clinical pretensions. Erickson seemed very aware of this, and often viewed a patient's problems as an intellectual challenge or puzzle. He sought ways to use the resources of the patient to bring about the solutions. He had faith in their ability. In many ways, the role of the therapist in such a framework is to inspire patients to rely on themselves and to get them to generate their own solutions and alternatives. Often this occurs in a rapid fashion that is surprising to both the therapist and patient. One

of us had been seeing a woman for therapy who had a great deal of interpersonal anxiety. Part of her problem centered around her shyness toward others and difficulty in meeting people. In the course of working with her, on her own she developed a terrific solution. She reported that she had gotten a job as an Avon lady. She needed extra money, and she also found that this was a way to meet new people, and it helped her to have a script to follow and know what to say. This became a springboard for dealing with other interpersonal concerns in her life. We could not have designed a better intervention. She did it on her own. If we give patients a chance, they often seem to have great ideas about what to do. If we listen and stand back a little, we may need only to inspire them and give them permission to succeed in their lives.

At the movies: Nice Guys Finish Last

As a therapist your role is often to challenge your clients. In therapy, it is often necessary to force encounters with that which is difficult for clients. It is also necessary to challenge erroneous assumptions clients may have, and to hold clients accountable for irresponsible behavior. Therapeutic change may often be somewhat painful for clients, for it may require that they get off their asses, and do something. If you as a therapist anger a client, it may mean that you are getting somewhere. He may not like what you say, but it may be true. We should take care not to underestimate the strengths of our clients; they can often tolerate

far more constructive confrontation than we realize. Therapists tend to walk on egg shells, waiting for clients to be ready to accept our interpretations. It is better to respect their actual strengths and to make fuller use of them. Sometimes, it may be necessary to challenge the complacency of a client in a strong manner, especially when the client is "playing games." Or if you want to be nice about it, you can give him a task to do, and tell him to come back only when it's finished. Therapists should not be chickens.

Some therapists seem reluctant to tell clients what reality is all about. They seem fearful of telling clients that behavior has consequences. They wrap patients in a protective cloud, and feel that the patient needs to become ready to face reality in a protracted, gradual manner. They rationalize and say that if they discussed distressing information with the client right now, it would overwhelm him and result in premature termination. In some ways, they become hostage to the client, seeking always to reach a delicate balance between helping the client and overwhelming him. But this prospect of overwhelming the client seems to be a greatly exaggerated risk. Imagine a lawyer who is reluctant to tell his client that if he goes ahead with his plan to rob a store, he might get caught and go to jail. Why do we assume that different rules operate in therapy? Why should a therapist be anxious about saying to a client that if you continue to cheat on your wife and she finds out, she might leave you? There should not be a separate set of rules for people with problems. The role of the therapist

is not protective, but corrective. Therapists need to tell patients about their reality. They need to respect their strengths, not foster their weaknesses. In some cases, it may be necessary to tell a client that he has gone too far, that it is too late, that he has to give up hope in a particular case. For example, a client may have been abusive to someone in a relationship, and then comes to therapy after he finds out that the other person wants out. In such a case, the therapist may have to tell the patient that it may be too late, that the damage has been done, and the relationship may well be over. Some therapists may feel that this needs to be done gradually over time; the patient needs to be brought to this realization slowly so as not to be overwhelmed. By why? In doing therapy, the therapist often encourages the patient to take risks, and be assertive. But shouldn't the same advice apply to the therapist himself? As therapists, we need to lose our preoccupation with being gentle and likable, and our acceptance that treatment needs to be a painstakingly slow process.

Constraints: Outrageous Acts

You can't make an omelet without breaking eggs. Therapists must take risks. Optimal treatment requires that we push the envelope of convention and dare to use the unexpected in order to challenge complacency. This sometimes involves breaking the rules in a way which liberates clients and helps them to see the arbitrariness of most social norms. Outrageous interventions that

stretch the limits of acceptability get the client's attention, are memorable, and offer an example of the human freedom to recast the rules when necessary. Weeping with clients, yelling, cheering, and laughing all can have an important place in therapy. Provoking, startling, and challenging clients makes them move.

When a therapist is overly constrained by convention, the client's potential to find new solutions is limited. The rules are sometimes part of the unworkable status quo the clients must be emboldened to transform. Clients need to see examples of risk-taking. A therapist's breaking loose, innovating there on the spot, and taking chances can humanize treatment, which increases its impact and meaning. A therapist who feels free, best frees his client.

As therapists we need to examine carefully the implicit rules we make that can preclude optimal responses in therapy. Many rules are based on clinical assumptions that are questionable. For example, in some cases, it may be helpful to get a client angry. That may be the best way to get the client to take action in his life or reevaluate his thinking. But as therapists we must always operate within certain specific limits. We don't hit patients. We don't have sex with patients. We don't take advantage of patients. We don't try to make them worse. Our aim is always therapeutic, guided by the goals of therapy. But within these parameters, therapists should feel much freer to roam and explore.

One risk that we need to take as therapists is to define when therapy is complete. When we have done what was required, and

gotten the patient moving in the right direction, we need to take the risk to say that the therapy is finished, and there is no further need for us to be involved. The patient must then use what he or she has learned, and move forward on his own. Many therapists have problems with this. They feel awkward bringing up the topic of termination, and therefore stall doing so. By default, clients often have to broach the subject first. Some therapists hold onto the client and justify doing so by saying they feel that additional "unresolved" issues need to be worked through, and that exits from therapy need to be gradual. The financial incentives for this failure in courage compound matters. However, in reality we do not need to wait for any deep understanding or insight to occur in the client. When the client has made the key changes, they can carry through by themselves, and they can mop up on their own. All of these risks are possible when we look at the client in a new light. We must see clients less in terms of their problems, and more in terms of their humanity. Clients are more like us than unlike us.

III. WHERE TO START THERAPY

How Erickson approached therapy

Rapport: Each Case is the First

Therapeutic interventions need to be consistent with the experience of the patient. It is important as a therapist not to take your understanding of what the patient says for granted, nor to assume

that patients' words mean the same thing to both of you. You are striving in every therapeutic relationship to communicate clearly about clients' experiences, and our somewhat idiosyncratic use of language is a constant barrier to this.

Your priority during a session is to enter this unique individual's reality and to try to comprehend it in its entirety. Worrying about the match between this client and those in particular diagnostic categories, or thinking too much about different etiologic models, can be distracting and actively compete with the sharing of experience you are trying to promote. Rapport requires more than an intellectual effort from the therapist, and demands full, focused attention. It is important to understand the phenomenological experience of the patient in the specific situation(s) where their problem occurs. This is more than simply being behavioral. Rather, it is important to look at the steps and sequences of both private internal and observed public behavioral events, and to look for critical steps in the problematic situation that may be being done wrong or in a defeating way. Assumptions the patient makes, actions he takes, things he is saying (inwardly and outwardly), and the ways he is experiencing the situation are all very important to consider. Once all aspects of this experience are understood fully, therapy interventions may be easy to fashion. For example, a patient that wanted to do better repeatedly, repeatedly saw herself as failing in valued situations. The therapist needed only to change her focus to seeing herself doing better and succeeding by mentally rehearsing what she wanted,

rather than what she feared. Her behavior came to match her mental images of success and satisfaction. In doing therapy, therapists need to focus on the experiential level of the client. This involves the actual sensations and concrete experience that the patient is going through, not his conceptualization or explanation of his experience. As a therapist, one needs to make relevant, experiential interventions. For example, telling stories often works better than explanations. Stories are more relevant to how the client experiences his everyday life and shares the experiences of others' through narrative accounts. Clients can easily associate or relate to stories that capture elements of what they are experiencing. Talking in general, conceptual terms about the dynamics of a problem (e.g., sibling rivalry) may go way over the client's head experientially. Telling a story about someone who had a brother and how they struggled with the issues they faced with that brother will access the same concerns about rivalry and offer solutions in a form that more readily translates to action. It seems that traditional therapies often overlook this most important aspect of therapy. They address the cognitive, affective, and behavioral aspects of experience, but all too often intervene on too abstract a level. Few have focused directly on the experiential, which encompasses all of these in an immediate, readily available manner.

Related to this aspect of therapy is the need for the therapist to exhibit experiential empathy. Erickson would often tell stories about his life that related to experiences similar to

those of this client. In doing so, he would offer a variety of solutions to the client in a very nonthreatening way. The therapist can do two things in telling stories. As he is communicating empathy, he is also offering solutions. In a somewhat indirect fashion, he can offer the client a menu of experiences related to the client's experience. The client can tailor what he is told to his own unique life situation. In such a case, the client can be creative in his own right, and find what works best for him. In a similar sense, a therapist can help a client access experiences the client previously saw as unrelated to their current problematic experience. This enables the client to learn to try new approaches when he is mistakenly treating the present situation as if it were one from the past. It also allows the client to apply skillful behaviors in new ways, when they discover unseen parallels between old and new situations. These efforts at change must be relevant to and consistent with the experiences of the patient. A large part of the therapist's work involves zeroing in on this important experiential level and not overshooting it, or being inconsistent with it.

Using words: What Does That Mean?

Choose your words carefully. Within this framework of therapy, what is often most awkward for therapists with more traditional backgrounds is using words differently than they have been using them. Traditionally, words have been used in therapy to gain information, or to organize data about a client in terms of a

particular therapeutic paradigm (e.g., the number of times a given behavior occurs). Therapists basically feel comfortable asking questions, giving feedback, and interpreting what is said. Central to their work has been the striving for enhanced awareness and understanding by the client. Unfortunately, to a large extent therapy has been bogged down by these efforts to gain more and more information and awareness, because this process doesn't necessarily promote change or growth. How much information is enough? How much awareness is necessary for change to occur? The part of therapy aimed at achieving change has often been accorded a very secondary role, and frequently is left to a so-called implicit process. As the client learns more and more, it is assumed that he will naturally and automatically change more and more. But this assumption is often proven false. All some clients learn to do is to explain their failures better; talking a good game isn't the same as playing well.

When using a briefer, Ericksonian framework it is often initially challenging for traditional therapists to use words with the explicit intention of producing change directly. They habitually slide back into talking about the client's experience, rather than trying to transform it. Understanding per se should not be a primary therapeutic focus or major concern. Therapists using this briefer Ericksonian framework are less likely to gain as much information about the client before proceeding with the change process. Therapists using this framework believe that change occurs by changing client's experiences. They assume that it is

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not necessary to know the cause of a problem before seeking a solution. They believe it is urgently important to produce desirable change. With this in mind, such therapists carefully use words as tools. They say something intentionally designed to produce a change in the client. Words have a much more directive function here than in traditional therapy. When words do not lead to desirable changes, the therapist working within this framework will search for other words, to better match the client's experience, in order to produce the desired change. Consequently, when a client does not understand or is confused by what the therapist says, the therapist does not see a need to increase the client's understanding, but looks at what was said and how it produced the confusion. Then, words are chosen to tailor the communication to reduce the confusion only as is necessary to produce the desired change. The therapist uses a titrating process, where the therapist works to match the client's level of experience with his words, and uses words in a relevant fashion to the client's experience to produce change. With this type of approach, the therapist does not operate at a meta-communication level to get the client to become more aware and hence to change. Rather, the client can relate directly to what the therapist says (it is not beyond his understanding) and consequently the client can follow through with the therapist's directive. Again, this may create difficulties for therapists, for they need to organize their words and what they say in new ways aimed at changing the client. Words are chosen for the impact they have on the specific client

and the criterion dictating the choice of words is their ability to promote change. The goal is not to get the client to agree with the therapist's formulations. Instead, the goal is to cut to the chase and transform the client. The therapist wants to create beneficial experiences, have the client engage in constructive change efforts, and access relevant experiential events, not become more aware of the dynamics of a problem. In many ways, the therapist has to become an "experiential programmer". Words are his tools and provide the means for bringing about experiential transformations. Right from the beginning, the therapist seeks direct change of the client's experience and life.

Therapists need to be conscious of the impact that specific words have on specific clients. Given their variable, idiosyncratic meanings, words must be selected with care in order to produce desired change. Hasty choice of words can unintentionally confuse, disparage, insult, pathologize, or discourage the client.

Therapists should tailor their use of specific words to maximize therapeutic effects. Doing this requires a keen sensitivity to how clients respond to language and a willingness to experiment in order to maximize your influence upon the client.

Simultaneously, in choosing language that will have the desired impact, it's important not to become self conscious, because this would disrupt the normal communication process. Keying in to the client's way of speaking, and comfortably adopting their manner, can facilitate communication. Attending to

particular words that evoke strong responses, as well as to those that seem to bewilder, can help you to fine tune your message. Regularly inquiring about any special, individual meanings and associations clients may have to particular words helps to clarify messages between therapist and client. Don't assume words mean the same thing to your client that they mean to you.

Observation: Assumptions Can Blind Us

Therapists need to be good observers of the effects they are having on clients, so they know in what directions they are leading clients. Whatever the therapist does, it has some impact on the patient. Every action or utterance communicates some direction for the patient to follow. There is really no such thing as non-directive therapy. There is therapy that gets to the point, and there is therapy that doesn't, that instead appears almost rudderless. In these poorly directed therapies, it is hard to discern what the goal is. In such cases, the client may seek to clarify the process by asking sometimes impertinent questions. This may be viewed as a "transference reaction" or "resistance", but really the client is trying to fill a void the therapist probably should not have permitted to exist in the first place. Therapists need to be fully aware of the directions they are giving, intended or not. The effectiveness of what a therapist does can be discerned through careful, attentive observation of the patient's immediate reactions to the direction, and by monitoring the steps the patient takes to create change. From this, the

therapist will know when to go further, when to back up, when to clarify, and when to stop.

Because when using this therapeutic approach, words are used in a much more focused and directive fashion, the therapist needs to be attuned to and observe the effects these words are having on his clients. In a sense, the therapist is involved in an experiment with only one subject. The therapist must face the challenge of assessing the effect that what he is doing is having on the client. Is it producing comfort, discomfort, confusion, anger? The therapist needs to observe in each individual case the unique indicators that the client provides about his experience, and gauge the impact of each intervention accordingly.

The therapist also needs to assess the client's motivation and desire for change. In order to do this, the therapist must be free of theoretical presumptions about what is going on in the client's life, and overcome a tendency to dwell on explanations of the client's problems. The therapist needs to observe on an empirical level if change is being produced in a desired fashion. Is therapy directing the client toward the desirable change? Monitoring clients' reactions in this way can be somewhat awkward at first. When using this framework, therapists are no longer primarily involved in discussing concerns with the client, but rather they are seeking to program the client experientially. In order to know if that programming is successful, therapists need to conscientiously monitor the effects they're having on the client. In a normal conversation, we may not be conscious of whether the

person we are talking to understands us. We may just react with little thought or awareness of their nonverbal cues which acknowledge receipt and understanding of what we had said, before taking our turn again. But in this type of brief therapy, the therapist has to focus on these cues that are ordinarily taken for granted, in order to assess where the client is on a continual basis, and to determine specifically what is going on experientially for the client. If the therapist fails to do this, therapy will lose its precision and be a hit or miss endeavor. The therapist needs to reach a point through his observations where he can accurately anticipate a client's change before it actually occurs. The therapist needs to know when to let the client access and process change, and when to intervene. As an observer, the therapist must become very attuned to the timing of what he says to the client, neither moving too fast nor too slow for the client. If he's a good observer, the therapist can pace himself to the client's ability and produce optimal desirable change. Also, as an observer, the therapist needs to be attuned to when the change has occurred, and therefore when therapy need go no further.

Traditional therapies have made much of nonverbal cues, but only in regard to reading the client's messages about what he feels, the incongruency with his statements, etc. This approach to therapy goes much further, for here the client's cues are used to time the interventions, tailor or change them, and stop them when indicated. This requires a great deal of concentration and attention on the part of the therapist. The therapist must

overcome longstanding habits of trying to explain or understand what's going on. Furthermore, the most influential interventions that will arise simply cannot be planned beforehand. The therapist cannot come to therapy with predefined solutions and still achieve the responsivity that's needed for optimal individualized treatment. Rather, the therapist must develop solutions within the session and tailor them to the client's immediate experience. In doing so, three basic steps come into play. One, the therapist needs to get a sense of the concrete experience of the client. Two, he needs to use words consistent with that concrete experience. Three, the therapist has to assess the effects those words are having on the client and if the client is changing. If nothing seems to be working, the therapist needs to review and go back over each of these, experience, words, and observation, until he finds the key. Traditional therapies have taught that the nature of the therapeutic experience (the techniques, the interventions, and the words... in effect the therapeutic script) could be written before the therapy session. According to this conceptualization, all therapists had to do was come prepared and plug the client into the process, and watch the changes occurring in terms of the theory. But this is a very inefficient, hit or miss kind of process. It can also be depersonalized and alienating for the client. Further, it often fails to address and use the unique experiences of the client.

Presenting problem: Fixing What's Wrong

Always treat the presenting problem. This is the starting point for therapy, and in most cases should be the ending point. Patients know what's bothering them or what their problems are. They come for help, and the therapist should help them. This does not mean that their problems are not related to other issues. But starting with the presenting problem is a must. For example, a couple may be having problems with their children, and come to therapy wanting help with them. They may also be having marital problems. One problem may be related to the other, or it may not be. Some therapists make the assumption that you have to treat the marital problems before you can treat the parental problems, even though the couple is requesting help only with the latter. It's usually better to start with the latter, for there is nothing that says a couple with marital problems cannot be good parents. In fact, working on the parental problems may improve the marital relationship.

Most of the time in therapy, patients have fairly delimited problems that they just cannot solve on their own, which form the basis for their distress. Most of the time it is not necessary to go any further. Why assume the worst if the patient doesn't?

IV. WHAT'S IMPORTANT FOR CHANGE

The source of therapeutic change in Erickson's work

Experiential change: Being Versus Thinking

Look for ways to produce meaningful experiential change. The

interventions used in this approach to therapy are similar to interventions commonly used in other therapies. But in this approach, they are tied to the presenting problem, rather than to a general therapeutic approach. For example, the empty chair technique used in gestalt therapy might be used in some general way to deal with feelings about others. Here, the same technique would be used to deal with a specific concern related to a particular presenting problem. Further, it would also be used to discern solutions and engage in some role playing, where desirable behaviors may be scripted. Therapists have a whole armamentarium of interventions that can be applied in therapy to produce desirable results. Sometime, interventions may be outrageous in their conception, but effective if employed. Here the therapist may need to overcome the constraints on his freedom to experiment. For example, in the case where Erickson had the mother-dominated physician get drunk to stop his mother's domineering ways, Erickson prescribed questionable behavior as a means to solve a pressing relationship struggle. There is a Sufi saying that it is often desirable to make a bad impression on undesirables. Therapists may have to use their humor and creativity to come up with effective interventions.

The aim of interventions is to produce change at a preverbal, experiential level, not simply cognitive or behavioral change. It was discussed before how even in cognitive therapy there needs to be an appreciation at some level of the absurdity of one's thoughts in order for cognitive therapy to be effective.

There are two basic ways to produce experiential change. The first way is internally, through working on the images, thoughts, feelings, and assumptions of the patient. The therapist can employ such things as role playing, humor, story telling, imagery training, trance, etc. The second way involves having the patient do something externally, such as carrying out a task to produce desirable change. The task can involve one trial learning, or it may involve gradually acquiring a new skill in a step-wise fashion.

In some cases, the kinds of changes involved may range over a whole variety of problems and require a lot of therapeutic work. In such cases, the therapy may involve a lengthy socialization process, such as Erickson's case of Harold. Here Erickson spent six years to basically reshape Harold's whole life. Therefore, in some instances the presenting problem may be very elaborate and involved. However, it is important for the therapist to know what direction he is heading in, and to arrange for experiential changes to occur. The patient should be continually changing in measurable ways as therapy proceeds.

Unconscious functioning: Beyond Awareness

Trust the patient's unconscious. Most of what goes on in our functioning occurs outside of direct awareness, and it is good that it does. If we had to be directly aware of all of that we were doing, we could not survive. An informational overload would paralyze us and interfere with coping. More important than this is the fact that there is not a simple division between conscious and

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unconscious experience. Rather, it appears that there are what can be called agents and subagents, that work together to do particular tasks, and may be independent from one another. Our overall functioning seems to be dependent on a whole range of these agents. Minsky has talked about a society of mind in this regard. Consequently, there are a whole range of resources in the form of these agents outside of direct awareness that could be used if we somehow could tap into them. Erickson seemed very aware of these hidden resources, and seemed further to understand that our consciousness may serve to fix our attention in such a way as to prevent us from using these underlying resources most fruitfully. It is like some of the agents have wrested control of our functioning and prevent others from being of help. Virginia Satir talked about the theater of self, and getting the many selves within our self to work together. Often, we on our own work to engage these other agents in our mind, when we are stumped by a dilemma and can find no solution. As we become frustrated, other agents may take the stage and provide what is needed. All of the time, our minds are working and doing. We need to learn how to tap into these resources as therapists. This is possible in therapy by getting the clients to look inward and trust their inner resources more fully. We do this in a practical way by helping the client to direct his attention in desirable ways. As experiential programmers, the kind of instructions we give to clients can either enlist these resources or block them.

The goal of successful therapy is not conscious understanding.

We have had several patients tell us that something we said had a terrific impact on them. Often, what they heard was not necessarily what we said. People tend to interpret what therapists do in ways that are useful to them. Further, they make changes and often are not aware of what was the cause of them. Much goes on outside of the scope of conscious awareness. Therefore, we need to overcome an occupational hazard of always striving to be up front and honest and having the patient know exactly what is going on. Too much conscious awareness may actually block some types of growth and change.

Therapists need to stop seeing understanding, insight, and awareness as therapeutic goals in and of themselves. When we were in graduate school, all the different schools of therapy used the same basic method. Get the patient talking about his problems, and lead him to understand them in terms of that particular school of therapy. Awareness was tantamount to therapeutic success. When in doubt about what to do, therapists were urged to just ask the client how he felt about what he had just said. But often clients in such therapy learn little more than how to talk about their problems. Talking articulately about problems doesn't solve them. If life outside of therapy doesn't get any better, the therapy has failed.

Often in therapy, we as therapists need to get the client to rely more on his own inner resources. We need to inspire the client to make changes and use his own creative potential. But direct exhortations are sometimes less influential than appeals at

a less conscious and obvious level. Indirect suggestive techniques elicit less reactance and reduce oppositionalism. We sometimes tell depressed clients a story about two mice that fell into a bucket of milk. The first mouse said, "What's the use in trying? We're going to drown anyway." He turned belly up, sunk to the bottom of the pail, and drowned. The other mouse said, "No way!" He kicked like hell, turned the milk to butter and jumped out of the pail! We tell the story and turn to the patient, and ask them what kind of mouse they are. We take the story seriously, and so do they. Every time we've told the story, patients have said that they were the mouse that jumped out of the pail. This acknowledgement becomes the basis for positive change largely on an unconscious level. Through this story we help to restore their power to respond in an active, constructive manner, and inspire them to rely on their resources and do better.

Identity: Responsible Self Creation

As a therapist you will directly and actively affect the identity of your patients. The therapist is in the business of creating a better identity for patients, because the notion that identity is fixed and static is primarily a fiction. The goal of therapy is actually not self discovery but change of self.

We are constantly revising who we are and our view of what significance particular events have in our lives. If we consider history, it becomes clear how changing context changes meaning. For example, Marxism had a great deal of credibility to many people

until the far-reaching collapse of communism in much of the world. Then its significance was drastically reduced. It is often hard to judge events accurately until something happens later. Each event has particular significance only within the context of other events. The same holds true with our identity. We are constantly revising the meaning of the events of our lives, and thereby redefining who we are. Further, as research shows, what we see happening now is largely a creation of our perceptions. In fact, we do not see only one thing out there, but create multiple drafts of what's going on, from which we select one or several views. And even these change. Our reality and our consciousness of self are not fixed things. However, we do have the illusion that they are. It has been said by Dennett (1991) that our brains function like parallel computers, continually generating multiple views of the world, but we create the illusion of a serial computer in which events flow in a narrative, sequential, and linear way. Within this illusion is the illusion of a constant self with a history. However, in reality this history is constantly being revised in terms of current events.

We have inherent power in the process of creating this fiction of self. We can reshape our selves in ways that are constructive and conducive to satisfaction. Erickson's work was consistent with this way of viewing consciousness. He saw the therapist's goal as changing the experience of the patient, and hence revising their identity. Rather than pursuing the traditional model of "know thyself", (seeking to discover what makes the client tick), he

sought to change the self. In an existential sense, we create who we are by what we do. And doing becomes, within the Ericksonian framework, the most important thing. He capitalized on the notion of making the person an active doer in his life. Erickson was also very aware of how the therapist can create the client's identity by how he chooses to identify the problem. He understood the importance of the illusions he created about the client. He chose healthier ones for his patients: that the patient was in control, had independence, responsibility, creativity, was an active doer. He helped the clients move forward with solutions that would improve the client's life. How different this is from therapies that identify the patient as having a problem and the need to talk about it in some ill defined manner. How different from therapies that foster dependency and passivity on the part of the client, and then tell the client that his problem is that he too passive in his life!

If a therapist accepts the client's current identity, and treats it as a fixed entity, this blocks the client's growth and development. Participating in a search for the client's "real self" embedded in their past is folly. Your trek through memories tampers with them and transforms them. Treating the recreated re-remembered self as fixed and final offers only fleeting satisfaction and the illusion of a closure which in fact is unattainable.

Statements such as, "You're the type of person that feels overwhelmed when there's too much stress", doom clients to a self

view that guarantees subsequent distress. A central objective of all therapy is to help clients take responsibility for the ongoing task of self creation. The last thing in the world we want to do is to take a temporarily distressed, demoralized individual and lock them into that negative identity. Yet all too often, our labels and explanations serve as stifling self-fulfilling prophecies. We must make clients aware of their ongoing power to choose to be someone new.

V. HOW CHANGE OCCURS

Hypnotic principles in Erickson's work

Reframing

Use what the client brings to therapy. Whatever the client does or says, it can be framed by the therapist in desirable ways to produce change. Any behavior, no matter how apparently inappropriate, pathological, or destructive, can be useful when presented in the right context. Consider the previously described case of the woman who used vomiting to kick her in-laws out of her house. The therapist should look for ways to restructure the nature of the patient's problem in order to use what was a problematic behavior as a positive solution. In many ways, a problematic behavior is often a crude attempt at a solution to a problem. Reframing is one of the most powerful tools that a therapist has.

Concentrated effect: Confusion

Have the client focus on desirable change. Always strive to keep the client focused on change, and moving in a desirable direction. As with the stray horse in Erickson's story, keep yanking him back on the road, keep him focused on therapeutic change. Furthermore, solving a problem requires new experiences or looking at old experiences in new ways. One of us once saw a woman in therapy who was a victim of date rape. The rape had occurred several years before and she had basically gotten over it. It wasn't affecting her life until she told a friend about it. The friend got her to join a rape victim's group. In this group, she was encouraged to talk about the rape. Her reluctance to do so was seen as denial. She did start talking about the rape, and began feeling steadily worse. This was because she was repeatedly reliving the rape that she hadn't thought about for years. She was becoming re-traumatized. In therapy she was told that there was no need to recall what had happened. Instead, it was suggested that it was perfectly alright to forget about the event, since she had successfully suppressed the experience until recently. She did much better after this. Simply recalling a traumatic experience is not helpful unless it is done in such a way that the patient can get a new perspective and move beyond it. The support group this woman had joined wasn't doing that. Vividly reliving the painful may cause needless pain.

In a similar sense, worrying is a form of rehearsing failure. When worrying, all we think about is how we will fail; we thereby

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prime ourselves for failure. Therapists need to focus their clients' attention on the desirable, even though clients often come to treatment expecting the opposite. The more therapists do this, the more likely their clients will succeed.

A critical factor in therapy is how the patient's attention is directed by the therapist. Traditional therapies want to know what's wrong and why it is wrong. They focus too much attention on what's wrong, and how the patient feels about it. Or in some ways worse, they let the patient's attention wander and deal with issues as they come up. From an experiential perspective, this has the effect of producing desirable changes in a hit or miss fashion. Within the current framework, the therapist focuses the patient on doing and rehearsing what is needed to be accomplished. Simply stated, the more one does something, the more one practices change, the better one will become at it. Therefore, the therapist should see change as learning a new skill that will help the client get what the client wants. In some cases, the therapist may need to bypass or overcome areas where the client's current experiential state interferes with the desired change.

Control

Arrange for the client to take control of his behavior. Often times, the client feels helpless or that he has little control over his actions. This belief is often reinforced by therapists who assume that the client lacks voluntary control over the symptom, and emphasize external attributions for problems (e.g., pressures

at work are making you depressed). This viewpoint has the advantage of alleviating the client's sense of blame and guilt, but exacts a huge penalty in terms of their feelings of powerlessness. Since accurately establishing the actual locus of control for events is hardly ever possible (perhaps it is only possible in extremely artificial, controlled, experimental circumstances), therapists should carefully consider the practical consequences of their arguably arbitrary choices about how to attribute responsibility for client's experiences. If they don't, they may do more harm than good.

The literature contains many examples of how even in cases where most people would argue that the locus of control clearly lies outside of an individual (e.g., that responsibility for a given episode of rape lies with the rapist, rather than with the victim), it may ultimately be most helpful to support a view of personal control (e.g., that the victim's choices about where to go set the stage for the rape). One explanation for this phenomenon is that an internal, personal attribution for such an unwanted event can help to restore a victim's hope of preventing a reoccurrence (whereas an external attribution of causation can leave one with lingering feelings of vulnerability and fear about the world's unpredictability).

This suggests that therapists need to evaluate the impact of explanations they might offer clients methodically, and to resist the temptation to cater to client's initial urge to be spared a sense of responsibility. It is often far more beneficial to help

clients recognize how it is always their internal interpretations of events, rather than the external events themselves, that produce their subjective reactions. From this perspective, all that is external is made potentially internally controllable.

We as therapists need to arrange for clients' control of much they view as uncontrollable. Often paradoxical approaches are quite useful for tricking the patient into demonstrating self-control. This alone may resolve the problem. Prescribing the symptom or giving instructions for monitoring the symptom often help clients regain a sense of control.

Dominant effect

Realize that a client will not change unless he really wants to. No matter how powerful you are as a therapist, if the client does not want to change, you will not be able to change him. In the end, it is the client that chooses whether he wants to change. Giving short assignments as a way of gauging client motivation can quickly help you keep from wasting energy in cases where clients have too strong an investment in the status quo.

In a similar sense, the interventions we make need to be tied to what the client wants. They need to give him the change he wants. When they are linked to these desires, they will be taken more seriously, and recommendations will be followed. Strong motivation facilitates the impact of therapeutic suggestions. Therapy will be more effective when it resonates clearly with the client's dominant motives.

Symptom alterations

Get the client to do something differently. Often times it may be necessary to get the client involved in any change in the desired direction and to then capitalize on it. Any seemingly therapeutic program, no matter how outrageous, may achieve this end. There is a great deal to be said for therapeutic ritual. Furthermore, it may not be possible to undo the entire problem, all at once but by making some alteration in it, a therapist can convince the patient that change is indeed possible. Sometimes, it may be necessary for the patient to have some modified form of a problem, because it serves some purpose. Finally, successfully performing simple tasks can be the basis for profound change.

VI. WHERE THERAPY ENDS

Process and termination

Redundant therapy: When to Quit

Know when to quit. Many therapists continue to rehash the same material, long after they've exhausted their power to change the client. Extending discussion about a client's problems, and processing their reactions to their attempts at change, often offer little additional therapeutic benefit. Continuing to meet to share these discussions should be distinguished from the more active treatment phase of therapy. Although some clients enjoy, and some may need, an ongoing supportive relationship, where possible the therapist should work to facilitate the client's establishment of

a less expensive means of obtaining this social support. Emphasis should be placed on locating resources within the community (for example, peer support groups, informal church, education, or work-related groups) or helping the client to build workable liaisons with family members, neighbors, or coworkers. Stringing clients along unnecessarily or unproductively is unethical. Once is enough -- don't fall prey to endless replays.

Repeated Consultation: Termination is a misnomer

Once a client always a client. The implications of the preceding chapters may seem jarring, threatening as they do the notion of a very long term therapeutic alliance (at least for some clients). Abandoning the lucrative business of extended, redundant therapy may seem to be a practice-killer. However, the problem-focused, client-centered approach, because it works and works quickly, generates a steady stream of return business. This framework does not see problems in living as stemming from deep-seated pathology in need of a cure. Instead, this model recognizes that episodic need for assistance with problems in living is normal, especially in today's often perplexing, overwhelming world of choices and constraints.

Therapists should play a role akin to that of a family physician, and be available for repeated consultation as need arises. By providing fast, quality service, therapists adept with this model will find themselves, as did Erickson, busier than they care to be.

In general, the model of therapy we have examined here does not get as specific as that developed by Bandler and Grinder, or many others. Instead, it outlines a framework in which to do therapy. It is hoped that when the reader now reviews Erickson's work and the work of others, what Erickson did will become much more understandable, and the reader as a therapist will be more successful in generating specific types of interventions stimulated by this reading. Like a zen koan, the answer is not useful unless one has understanding of the overall philosophy and framework.

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